DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G087	A. BUILDING _____ B. WING _____	06/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL FOUNDATION	722 "L" STREET, NE WASHINGTON, DC 20002

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 8, 2011 through June 10, 2011. A sample of two clients was selected from a population of two males with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with one client and staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.	W 000	Symbral's governing body will ensure that all required policies are implemented to safeguard and provide habilitation to the individuals we serve. In addition, these policies will be aligned to the present Health & Wellness Standards, as well as other best practices guide. Symbral's governing body and QA Team will continue to monitor to ensure compliance.	6/20/11 and ongoing
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations of verbal abuse to the administrator within five working days of the incident, for one two sampled clients. (Client #1) The finding includes: On June 9, 2011, beginning at 1:25 p.m., review of incident reports and corresponding investigations revealed that on August 26, 2010, Client #1 was verbally abused by his 1:1 staff while at the day program. Further review revealed that on December 22, 2010, Client #1 was verbally threatened by facility staff that	W 156	Symbral IMC has updated the investigative report form to include a review section for Symbral's Administrator's (CEO) signature as an affirmatioo of her knowledge of all incident investigative findings within five working days. Symbral's governing body & QA Team will continue to monitor to ensure compliance. Received 6/24/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	6/20/11 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda M Agee	CEO	6/23/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 156	Continued From page 1 supported him in his home and at the day program. Both investigations were completed and signed off on by the facility's Incident Management Coordinator (IMC). However, there was no evidence that administrators had reviewed and signed off on the investigations within five working days. Interview with the Qualified Intellectual Disability Professional (QIDP) on June 9, 2011, at approximately 1:50 p.m., acknowledged that the facility's administrators had not reviewed and signed the two aforementioned investigative reports within five working days.	W 156	Continued from page 1.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the Qualified Intellectual Disabilities Professional (QIDP) monitored services, for two of two sampled clients. (Clients #1 and #2) The finding includes: 1. Cross refer W193. The facility's QIDP failed to ensure 1:1 staff demonstrated competency in implementing Client #1's behavior support plan. 2. Cross refer to W249. The facility's QIDP failed to ensure Client #1 received continuous active treatment in accordance with the	W 159	(1,2,3) QIDP, House Manager (s) and all staff working with individuals # 1 & 2 received re-training on 6/24/11 on implementation for BSP, adherence to Meal Time Protocols and Portion Controls. Symbral's governing body, QA Team, QIDP, and House Manager will continue to monitor to ensure compliance.	6/24/11 and ongoing

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W 159	Continued From page 2 interdisciplinary team (IDT) recommendations. 3. Cross refer to W460. The QIDP failed to ensure that Clients #1 and #2 received well balanced, nutritious meals in accordance with their dietary orders.	W 159	Continued from page 2.	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to demonstrate competency in the implementation of a client's Behavior Support Plan (BSP), for one of two sampled clients. (Client #1) The finding includes: Cross refer to W249. The facility failed to ensure that 1:1 staff demonstrated competency in implementing Client #1's Behavior Support Plan (BSP).	W 193	Crossed referenced and adopted with W159.	6/24/11 and ongoing
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249	Crossed referenced and adopted with W159 and W193.	6/24/11 and ongoing

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W 249	Continued From page 3	W 249	Continued from page 3.	

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the facility staff failed to ensure a client's Behavior Support Plan (BSP) was implemented consistently, for one of two sampled clients. (Client #1)

The finding includes:

The facility failed to ensure that Client #1's 1:1 staff remained in close proximity in accordance with his BSP, as evidence below:

On June 8, 2011, at 4:10 p.m., Client #1 was observed to walk over to the dining table to shake my hand and sat down while his 1:1 staff remained in the kitchen preparing dinner. At 4:15 p.m. the 1:1 staff remained in the kitchen preparing dinner while Client #1 remained at the dining table with the surveyor. At 4:27 p.m., Client #1 answered the cordless telephone located in the living room area and brought the phone to his 1:1 staff in the kitchen. At 5:35 p.m., Client #1 received verbal prompts to back up when standing to close to the female staff. During this time, the 1:1 staff remained in the kitchen. On June 9, 2011, at 4:48 p.m., Client #1 was left alone in the living room for approximately one minute while his 1:1 staff walked upstairs.

Interview with the 1:1 staff on June 8, 2011, at approximately 4:42 p.m., revealed that Client #1 received 1:1 staffing 24 hours a day to manage his maladaptive behaviors and safety. (i.e. inappropriate touching, invading another person's personal space and sexually propositioning another person, cursing, yelling, screaming, and

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W 249	Continued From page 4 making threats, refusing to comply with staff requests, verbal aggression, and physical aggression). Further interview with Client #1's 1:1 staff acknowledged that he did not remain in close proximity at all times as observed on June 8, 2011. Review of Client #1's BSP dated February 28, 2011, on June 10, 2011, at 9:43 a.m., confirmed the 1:1 staff's interview of the aforementioned maladaptive behaviors. Further review of Client #1's BSP revealed the 1:1 staff must remain within close proximity at all times (i.e., home, community, day, and while being transported). The BSP also added that Client #1's 1:1 staffing was in place for safety precautions relative to sexually propositioning others. At the time of the survey, there was no evidence that Client #1's 1:1 staff implemented his BSP as recommended.	W 249	Continued from page 4.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with each clients needs, for one of two sampled clients. (Client #1) The finding includes: Cross Refer to W455. The facility's nursing staff failed to ensure proper infection control	W 331	LPN Case Manager re-inserviced medication nurse on Health & Wellness Practices relating to Prevention and Control of infection. Symbral's governing body, QA Team, DON, LPN Case Manager, QIDP and House Manager will provide oversight.	6/20/11 and going

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W 331	Continued From page 5 procedures were used prior to administering Client #1's prescribed eye drops.	W 331		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for two of two clients residing in the facility. (Clients #1 and #2) The finding includes: The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On June 9, 2011, at 2:13 p.m., interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed that there were three designated shifts (8:00 AM - 4:00 PM; 3:00 PM -11:00 PM and 11:00 PM - 8:00 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (9:00 AM - 9:00 PM and 9:00 PM - 9:00 AM) for the weekend (Saturday/Sunday). Review of the facility's fire drill log records on June 13, 2011, beginning at 2:19 p.m., revealed that no drills were held during the weekday morning shift from October 2010 through December 2010. This was acknowledged by the facility's QIDP and the House Manager on June 10, 2011, at 11:42 a.m.	W 440	QIDP redo fire drill calendar to incorporated implementation of Evacuation Drills across specified shift (8:00 am – 4:00 pm weekdays) and utilization of all exit areas to include back door and basement door. In addition, House Manager (s) and all Staff were inserviced as explained done. Symbral's governing body, QA Team, QIDP and House Manager (s) will monitor to ensure compliance.	6/24/11 and ongoing
W 441	483.470(i)(1) EVACUATION DRILLS	W 441		

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W 441	Continued From page 6 The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for two of two clients residing in the facility. (Clients #1 and #2) The finding includes: Interview with the Qualified Intellectual Disabilities Professional (QIDP) on June 9, 2011, at 2:13 p.m., revealed that the facility had at least three methods of egress (front door, back door, and the basement door). Review of the facility's fire drill records on June 9, 2011, beginning at 2:19 p.m., revealed that most of the fire drills were conducted utilizing the front door exit. Further review of the fire drill records revealed that the back door and basement door exit had not been used since June 2010. This was acknowledged through additional interview with the QIDP on the same day at approximately 12:05 p.m. There was no evidence on file at the time of survey to substantiate that all exits were used.	W 441	QIDP redo fire drill calendar to incorporated implementation of Evacuation Drills across specified shift (8:00 am – 4:00 pm weekdays) and utilization of all exit areas to include back door and basement door. In addition, House Manager (s) and all Staff were inserviced as explained done. Symbral's governing body, QA Team, QIDP and House Manager (s) will monitor to ensura compliance.	6/24/11 and ongoing
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the	W 455	Crossed referenced and adopted with W331.	6/20/11 and ongoing

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W 455	Continued From page 7 prevention and control of infection and communicable diseases for one of two sampled clients. (Client #1) The finding includes: The facility's nursing staff failed to ensure proper infection control procedures were used prior to administering Client #1's prescribed eye drops. On June 8, 2011, at approximately 6:44 p.m., the Licensed Practical Nurse (LPN) was observed to wash her hands with soap and water prior to administering medications. At 6:45 p.m., the LPN provided minimal assistance to Client #1 as he punched his medications into the medication cup and consumed the medications independently. The LPN placed the medications back into the medication cabinet. At approximately 6:50 p.m., the LPN was then observed to administer one eye drop to both eyes of Client #1 with her bare hands. She was not observed to wash and/or sanitize her hands before administering the eye drops. Interview with the LPN coordinator on June 10, 2011, at approximately 12:00 p.m., revealed that the medication nurse should have washed her hands or place gloves on prior to administering Client #1's eye drops.	W 455	Continued from page 7.	
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.	W 460	Food & Nutrition Consultant re-trained all staff working with individuals #1 and #2 on "Adherence to Meal Time Protocol (Modified diets) and Portion Control as specified".	6/24/11 and ongoing

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W 460	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients received their prescribed modified diets as ordered by the physician, for two of two sampled clients. (Clients #1 and #2) The finding includes: The facility failed to ensure that Clients #1 and #2 received a well-balanced diet as prescribed by their Primary Care Physician (PCP) to ensure their nutritional needs, as evidenced below: On June 8, 2011, at 4:10 p.m., Client #1 and #2 was observed sitting on the sofa chairs listening to music and watching television. The clients appeared to look a little overweight. At 5:45 p.m., Staff #1 was observed to place two large scoops of snap peas and white rice onto the clients' plates using a silver spatula during the dinner meal. The staff also placed two pieces of wheat bread with margarine onto the clients plates. Review of the June 2011 Physician's Orders (PO's) on June 9, 2011, at 3:35 p.m., and 5:20 p.m. revealed that Client #1 was prescribed an 1800 calorie diet and Client #2 was prescribed a 1500 calorie diet. Interview with Staff #1 on June 9, 2011, at 4:45 p.m., confirmed that on June 8, 2011, he did not use measuring cups to measure the clients food. When asked how did he know that Client #1 and #2 received the appropriate amount of food, Staff #1 replied by saying, "I know the amount, I've been doing this for years now."	W 460	In additioa staff working at the time of survey received disciplinary action to this regard. Symbral's governing body, QA Team, Nutritionist, DON, LPN Case Manager, QIDP and House Manager will continue to monitor to ensuro compliance.	6/24/11 and ongoiag

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W 460	Continued From page 9 On June 10, 2011, at approximately 9:50 p.m., review of the dinner menu for June 8, 2011, revealed that client's prescribed an 1800 calorie diet was to receive 1 cup of white rice, 1 cup of snap peas, one slice of wheat bread, and a teaspoon of margarine. Further review of the dinner menu revealed that client's prescribed a 1500 calorie diet was to receive a 1/2 cup of white rice, 1/2 snap peas, and a slice of wheat bread. Note: It should be noted that Client #1's desirable body weight (DBW) is 128 lbs - 168 lbs. His current weight is 190 lbs. Client #2's DBW is 150 lbs - 192 lbs. His current weight is 213 lbs.	W 460	Continued from page 9.	

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I 000	INITIAL COMMENTS	I 000	Symbral's governing body received deficiencies as cited, we will ensure that corrective measures are implemented to prevent reoccurrences.	6/20/11 and ongoing
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure residents received their prescribed modified diets as ordered by the physician, for two of two sampled residents. (Residents #1 and #2) The finding includes: The GHPID failed to ensure that Residents #1 and #2 received a well-balanced diet as prescribed by their Primary Care Physician (PCP) to ensure their nutritional needs, as evidenced below: On June 8, 2011, at 4:10 p.m., Resident #1 and #2 was observed sitting on the sofa chairs listening to music and watching television. The residents appeared to look a little overweight. At 5:45 p.m., Staff #1 was observed to place two large scoops of snap peas and white rice onto the residents' plates using a silver spatula during the dinner meal. The staff also placed two pieces of wheat bread with margarine onto the clients plates. Review of the June 2011 Physician's Orders (PO's) on June 9, 2011, at 3:35 p.m., and 5:20	I 042	Food & Nutrition Consultant re-trained all staff working with individuals #1 and #2 on "Adherence to Meal Time Protocol (Modified diets) and Portion Control as specified". In addition staff working at the time of survey received disciplinary action to this regard. Symbral's governing body, QA Team, Nutritionist, DON, LPN Case Manager, QIDP and House Manager will continue to monitor to ensure compliance.	6/24/11 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rhonda M Deverb TITLE CEO (X6) DATE 6/23/2011

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I 042	Continued From page 1 p.m. revealed that Resident #1 was prescribed an 1800 calorie diet and Resident #2 was prescribed a 1500 calorie diet. Interview with Staff #1 on June 9, 2011, at 4:45 p.m., confirmed that on June 8, 2011, he did not use measuring cups to measure the residents food. When asked how did he know that Resident #1 and #2 received the appropriate amount of food, Staff #1 replied by saying, "I know the amount, I've been doing this for years now." On June 10, 2011, at approximately 9:50 p.m., review of the dinner menu for June 8, 2011, revealed that resident's prescribed an 1800 calorie diet was to receive 1 cup of white rice, 1 cup of snap peas, one slice of wheat bread, and a teaspoon of margarine. Further review of the dinner menu revealed that resident's prescribed a 1500 calorie diet was to receive a 1/2 cup of white rice, 1/2 snap peas, and a slice of wheat bread. Note: It should be noted that Resident #1's desirable body weight (DBW) is 128 lbs - 168 lbs. His current weight is 190 lbs. Resident #2's DBW is 150 lbs - 192 lbs. His current weight is 213 lbs.	I 042	Continued from page 1.	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectual Disabilities	I 090	Work request order form was completed by House Manager on same day 6/10/11 and submitted to Maintenance Department.	6/20/11 and ongoing

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	HFD03-0005	A. BUILDING _____ B. WING _____	06/10/2011

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I 090	Continued From page 2 (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for two of two sampled residents. (Residents #1 and #2) The findings include: Observation and interview with the facility House Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) on June 10, 2011, beginning at 1:47 p.m., revealed the following: Interior 1. The bathroom window located on the first level was observed to be inoperable. The bathroom window would not to open. Exterior 2. The lint trap outside the facility was observed with heavy build up of dirt and rubbish. 3. The fence located at the front entrance of the facility was observed to have a whole at the bottom. The QIDP and the HM acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.	I 090	Itemized job descriptions 1-3 were completed on 6/15/11. QA Tenm, QIDP, House Manager and Maintenance Engineer will continue to monitor to prevent reoccurrence.	6/20/11 and ongoing
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by:	I 135	See page 4.	

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I 135	Continued From page 3 Based on interview and record review, the group home for intellectuall disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for two of two residents residing in the facility. (Residents #1 and #2) The finding includes: The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On June 9, 2011, at 2:13 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that there were three designated shifts (8:00 AM - 4:00 PM; 3:00 PM -11:00 PM and 11:00 PM - 8:00 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (9:00 AM - 9:00 PM and 9:00 PM - 9:00 AM) for the weekend (Saturday/Sunday). Review of the GHPID's fire drill log records on June 13, 2011, beginning at 2:19 p.m., revealed that no drills were held during the weekday morning shift from October 2010 through December 2010. This was acknowledged by the GHPID's QIDP and the house manager on June 10, 2011, at 11:42 a.m.	I 135	Fire Drill Calendar now reflects specified evacuation drills for cited shift. House Manager (s) and staff were re-trained on updated fire drill calendar. Symbral's governing body, QA Team, QIDP and House Manager (s) will continue to monitor to ensure compliance.	6/24/11 and ongoing
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group for persons with intellectual	I 180	(1,2,3) QIDP, House Manager (s) and all staff working with individuals # 1 & 2 received re-training on 6/24/11 on implementation for BSP, adherence to Meal Time Protocols and Portion Controls. Symbral's governing body, QA Team, QIDP, and House Manager will continue to monitor to ensure compliance.	6/24/11 and ongoing

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I 180	Continued From page 4 disabilities failed to ensure that the Qualified Intellectual Disabilities Professional (QIDP) coordinated and monitored services, for two of two sampled clients. (Clients #1 and #2) The finding includes: 1. Cross refer W193. The facility's QIDP failed to ensure 1:1 staff demonstrated competency in implementing Client #1's behavior support plan. 2. Cross refer to W249. The facility's QIDP failed to ensure Client #1 received continuous active treatment in accordance with the interdisciplinary team (IDT) recommendations. 3. Cross refer to W460. The QIDP failed to ensure that Clients #1 and #2 received well balanced, nutritious meals in accordance with their dietary orders.	I 180	Continued from page 4.	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with intellectual disabilities staff failed to ensure a resident's Behavior Support Plan (BSP) was implemented consistently, for one of two sampled residents. (Resident #1) The finding includes: The GHPID failed to ensure that Resident #1's 1:1 staff remained in close proximity in accordance with his BSP, as evidence below:	I 422	Behavioral Specialist re-trained QIDP, House Manager (s) and all staff working with individual #1 on his BSP and 1:1 job duties. Symbral's governing body, QA Team, Behavioral Specialist, QIDP and House Manager will continue to provide oversight.	6/24/11 and ongoing

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I 422	Continued From page 5 On June 8, 2011, at 4:10 p.m., Resident #1 was observed to walk over to the dining table to shake my hand and sat down while his 1:1 staff remained in the kitchen preparing dinner. At 4:15 p.m. the 1:1 staff remained in the kitchen preparing dinner while Resident #1 remained at the dining table with the surveyor. At 4:27 p.m., Resident #1 answered the cordless telephone located in the living room area and brought the phone to his 1:1 staff in the kitchen. At 5:35 p.m., Resident #1 received verbal prompts to back up when standing to close to the female staff. During this time, the 1:1 staff remained in the kitchen. On June 9, 2011, at 4:48 p.m., Resident #1 was left alone in the living room for approximately one minute while his 1:1 staff walked upstairs. Interview with the 1:1 staff on June 8, 2011, at approximately 4:42 p.m., revealed that Resident #1 received 1:1 staffing 24 hours a day to manage his maladaptive behaviors and safety. (i.e. inappropriate touching, invading another person's personal space and sexually propositioning another person, cursing, yelling, screaming, and making threats, refusing to comply with staff requests, verbal aggression, and physical aggression). Further interview with Resident #1's 1:1 staff acknowledged that he did not remain in close proximity at all times as observed on June 8, 2011. Review of Resident #1's BSP dated February 28, 2011, on June 10, 2011, at 9:43 a.m., confirmed the 1:1 staff's interview of the aforementioned maladaptive behaviors. Further review of Resident #1's BSP revealed the 1:1 staff must remain within close proximity at all times (i.e., home, community, day, and while being	I 422	Continued from page 5.	

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I 422	Continued From page 6 transported). The BSP also added that Resident #1's 1:1 staffing was in place for safety precautions relative to sexually propositioning others. At the time of the survey, there was no evidence that Resident #1's 1:1 staff implemented his BSP as recommended.	I 422	Continued from page 6.	